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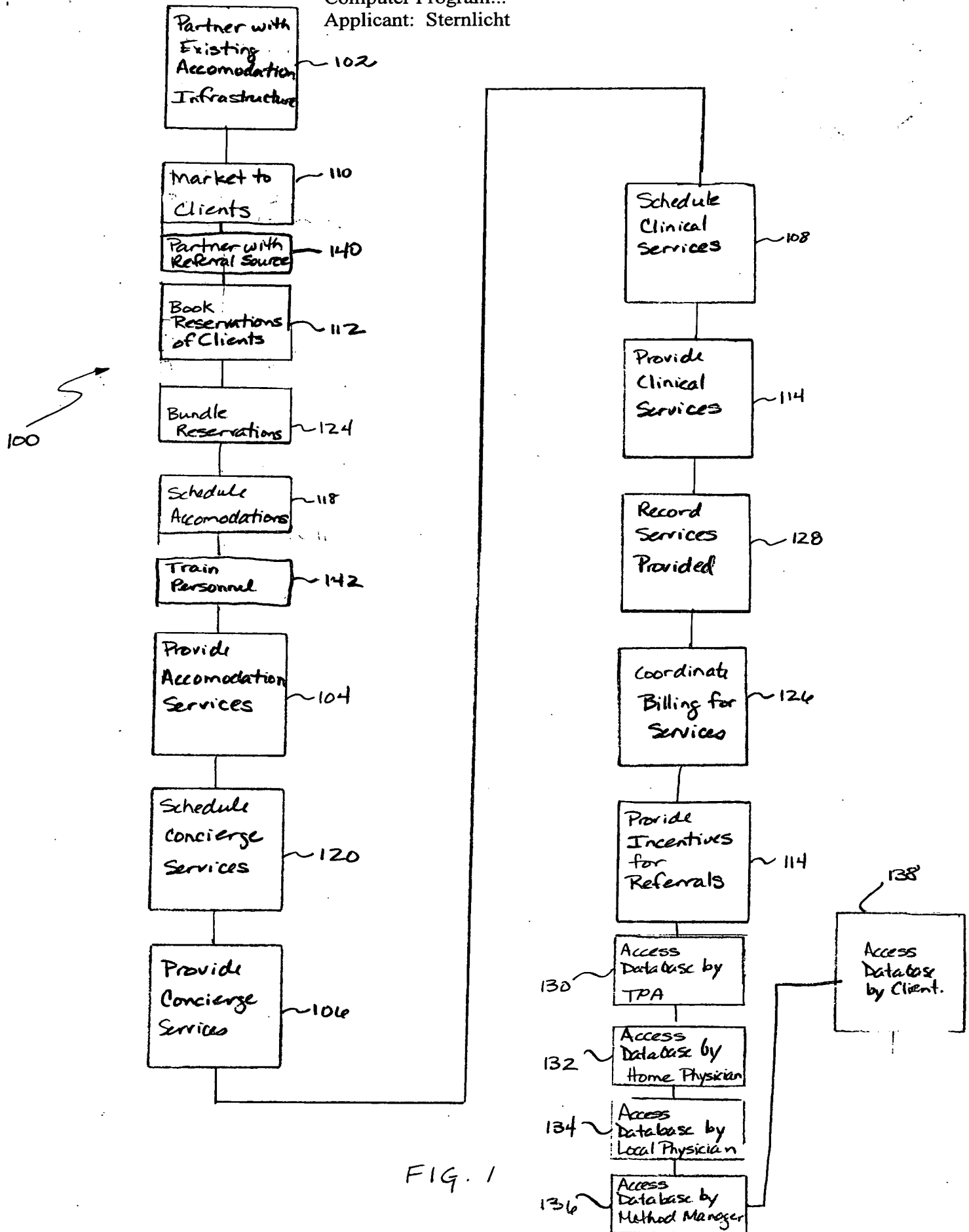
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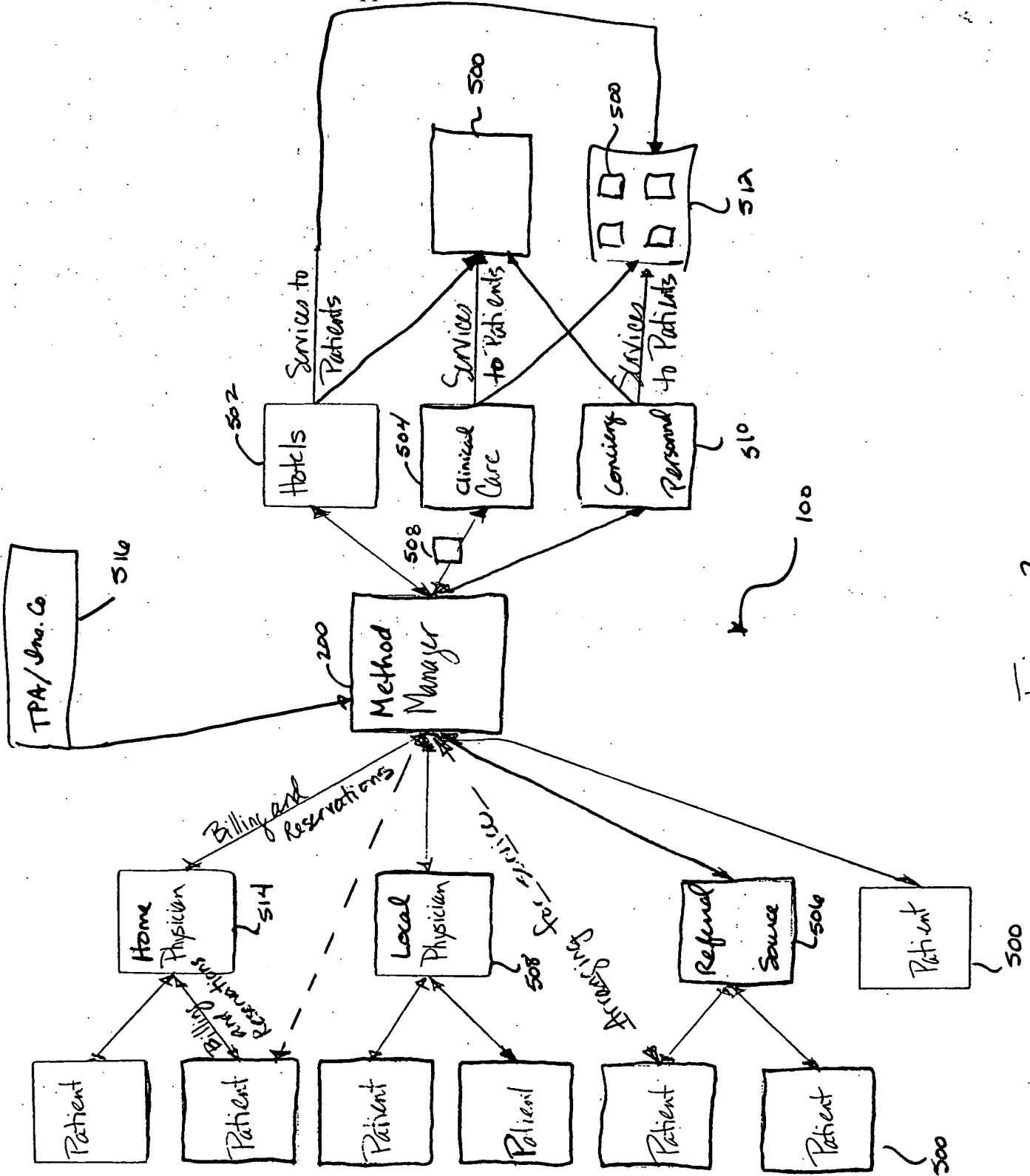
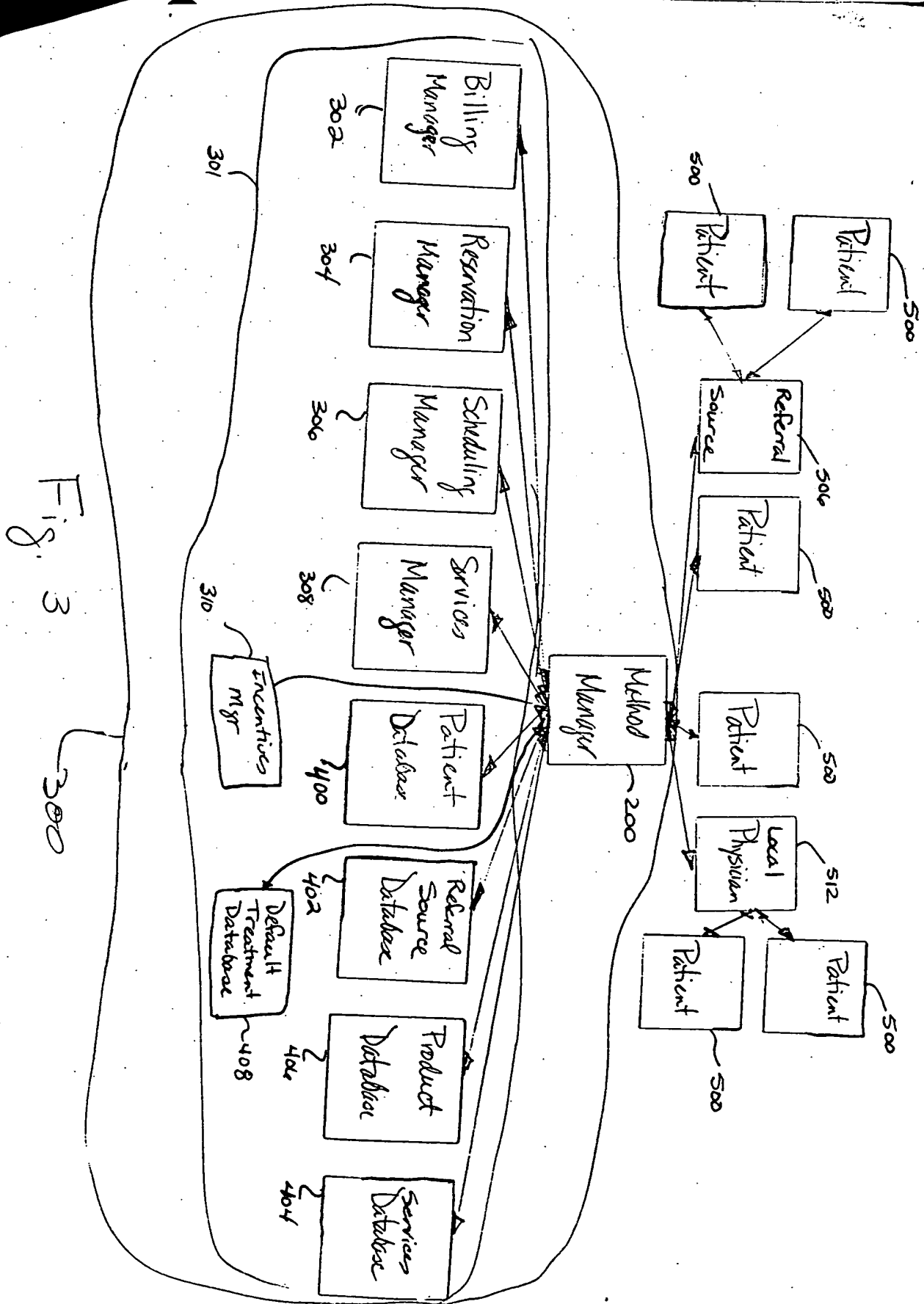


Fig 2



Care
Processor
301

Clock
604

Processor
602

Communication
Port
600

606

Program 608

Patient Database 400

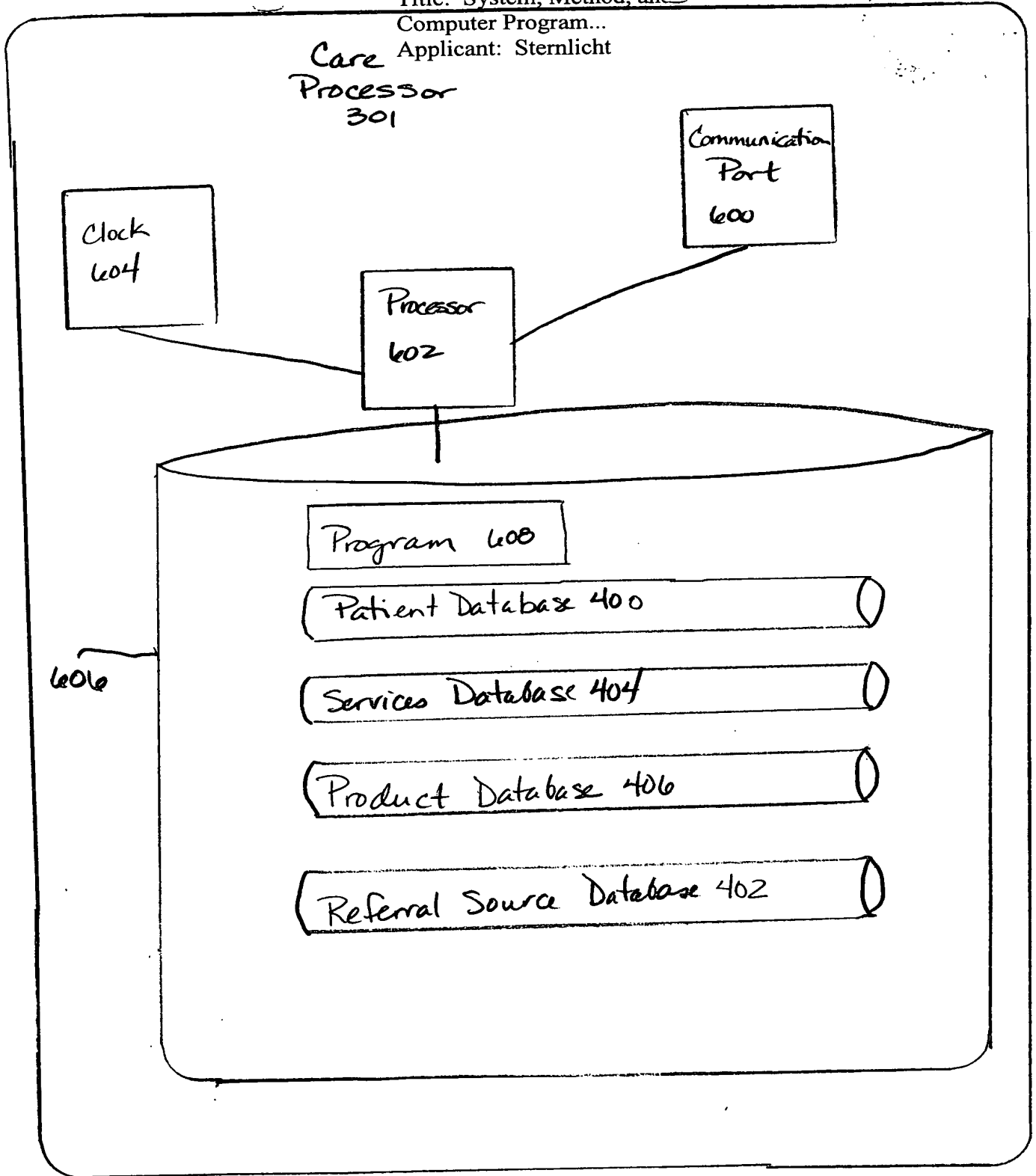
Services Database 404

Product Database 406

Referral Source Database 402

301

FIG. 4



Patient Identifier 614	Patient Name 618	Patient Address 620	Geographical Location for Treatment and/or After Care 622	Medical Facility Identifier 624	Local Physician Identifier 626	Local Physical Contact Information 628	TPA/Insurance Company Identifier 630	Home Physical Identifier 632	Home Physician Contact Information 634	Expected Start Date Identifier 636	Expected Stop Date Identifier 640	Expected Length of Stay and Accommodation 642	Medical Procedure or Care Identifier 644

An Accommodation Preferences Identifier 646	Concierge Services Preferences 648	Personal Emergency Contact Information 650	Billing Status Identifier 652	Referral Source Identifier 654	Bundle Identifier 656	Reservation Identifier 616	Patient Birth Date 658	Patient Sex Identifier 638	Patient Allergies 739	Anniversary of the Procedure/Recovery 660	Default After Care Protocol and Notes 662	Prescribed After Care Protocol and Notes 664	Medical Record Information 666

FIG. 5

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Applicant: Sternlicht

Referral Source Identifier 654	Referral Source Name 672	Referral Source Contact Information 674	Billing Type Information 676	Billing Status Information 652	Incentive Information 680	Client Patient Identifier Information 614	Medical Procedure or Care Identifier 644	Incentives Received Identifier 678	Incentives Due Identifier 682	Referral Information 683

FIG. 6

Patient Identifier 614	Patient Name 618	Reservation Code 616	Bundle Identifier 656	Service Type Identifier 692	Service Provider Identifier 690	Time Identifier 694	Date Identifier 696	Cost Identifier 698	Billing Status Identifier 652

FIG. 7

at No. H0649/7001
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Applicant: Sternlicht

Product Identifier 704	Product Price 706	Availability Identifier 708	Product Ingredients 710	Prescribed Uses for the Product 712	Medical Procedure or Treatment Identifier 644	Provider Identifier 714

FIG. 8

Medical Procedure or Treatment Identifier 644	Medication Type Identifier 724	Medication Dosage Identifier 726	Treatment Type Identifier 728	Treatment Practice Identifier 730

FIG. 9

Docket No. H0649/7001
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 Computer Program...
 Applicant: Sternlicht

PRACTICE PROFILE

Prepared by:	Date:
--------------	-------

Institution:		
Location:		
Address:		
City	State	Zip

Referral Potential				Attitude
Q1	Q2	Q3	Q4	
Pats.				

Tel. (Switch)	
Fax:	
Website:	

Key Personnel					
Contact	Title	First name	Initials.	Last Name	Position Title

Types and Volumes of Patients	Services Required	Special Needs

Referral Process	Agreed Action (What)	Who?	When?

Marketing Process	Agreed Action (What)	Who?	When?

Training Process	Agreed Action (What)	Who?	When?

Relationship Building	Agreed Action (What)	Who?	When?

Fig. 10

FIG. 11A

Docket No. H00471/001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

TITLE: TUBE FEEDING MANAGEMENT PROTOCOL

PURPOSE: To outline the nursing management of patients receiving continuous, intermittent, or cyclic enteral tube feedings via nasogastric, gastrostomy, duodenostomy, or jejunostomy tube.

LEVEL OF PERSONNEL: RN LPN

PURPOSE: Tube feedings are employed to meet nutritional needs including hydration requirements when normal oral intake is altered or contraindicated. The potential for tube displacement puts these patients at risk for aspiration pneumonia, or peritonitis.

- MD ORDER**
1. Validate that tube feeding order states formula, volume, strength, rate, time span, and method of delivery (i.e. continuous, cyclic, bolus or gravity drip).
 2. Measure, at time of feeding tube insertion, the length of visible tube and record on NPR.
- ASSESSMENT**
4. Assess for tube placement q 8 hours and before each intermittent feeding or medication administration, using at least two of the following measures:
 - a- measure and compare length of visible tube to initial measurement
 - b. aspirate gastric or small bowel contents (5-10ml, observe for appropriate color and consistency)
 - c. instill 10 ml of air into tube while auscultating stomach (gastric only)
 5. Assess gastrostomy/jejunostomy site q 24 hours for:
 - a. leakage of formula around tube
 - b. signs of infection (redness, induration, purulent drainage)
 6. Assess patient's fluid balance q 24 hours:
 - a. compare I/O, note fluid imbalances
 - b. monitor weight changes
 - c. monitor lab values (electrolytes, BUN, Cr.)
 7. Assess general abdominal/digestive status q 8 shift:
 - a. assess bowel sounds
 - b. observe for signs/symptoms of feeding intolerance: repeated nausea/vomiting, cramping, diarrhea or gastric residual >100ml/1 hour.

Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 11B

REPORTABLE
CONDITIONS

8. Weigh patient q AM, unless otherwise rdered.
9. Maintain l&O q 8 hours.
10. Report promptly to MD:
 - a. suspected displacement of feeding tube
 - b. suspected aspiration, i.e. SOB, elevated temperature
 - c. obstruction of feeding tube
 - d. abdominal distention, nausea/vomiting, cramping, diarrhea, constipation
 - e. fluid-electrolyte imbalance
 - f. gastric residual >120 ml for 2 hours for adults, 0-3 month >30, 3-12 months >45, 14yr+ > 60, if on bolus > 1/3 of previous feed.
 - g. suspected formula leakage around gastrostomy or jejunostomy
 - h. temperature >101°F.
11. Administer all formulas at room temperature.
12. Elevate HOB 45 degrees during feeding and for 1 hour following bolus or gravity feed.
13. Flush tube with 5ml for pedi, 10 ml for adult of warm water when feeding is interrupted, stopped, or after each intermittent feeding.
14. Flush tube q 4 hours with 5ml of warm tap water if feeding is continuous.
15. Stop gastric tube feeding if patient is placed flat or in Trendelenberg.
- 16.. Measure gastrostomy residual q 4 hours or before every intermittent feeding:
 - a. if residual is > 100 ml, HOLD feeding for 1 hour.
 - b. Recheck residual, if still > than 100 ml, HOLD and notify MD.
Reinstill aspirate.
17. Hold feeding for 1 hour if patient is nauseated, vomiting, or abdominal distention is present, if symptoms do not improve, notify MD.
18. Only hang a 4 hour supply of formula, do not leave open formula containers at room temperature for m re than 1 hour.
19. Change formula bag/tubing q 48 hours.

INFECTION

Packet No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 12A

TITLE: VENIPUNCTURE FOR BLOOD SAMPLING

LEVEL OF PERSONNEL: RN, LPN,

DESIGNATED CLINICAL AREA: All

PURPOSE: To obtain routine blood samples.

APPLICABLE POLICY STATEMENTS:

Individuals must successfully complete the training program to perform venipuncture for blood sampling.

A physician's order must be obtained for each test.

CRITICAL ELEMENTS:

1. Use of site in antecubital fossa is preferred if a vein is easily palpable. If a vein is not easily identified, sites in the lower arm or hand may be used, but only as a last resort.
2. Blood samples should not be drawn from an arm with a continuous IV infusion. For patients who should not have venipuncture performed in one arm, notify RN caring for patient, if applicable. IV infusion should be turned off in order to be able to draw blood.

EQUIPMENT:

Venject (may substitute a #23 gauge butterfly needle and syringe)
Appropriate specimen tube with labels
Alcohol swabs
Gauze sponge
Tourniquet
Disposable gloves
Plastic bags for specimen transport
Appropriate lab requisitions

NURSING ACTIONS:

1. Identify the patient.
2. Position patient's arm.
3. Select site for venipuncture. (Figure 1)
4. Apply tourniquet proximal to chosen site.

SPECIAL CONSIDERATIONS:

4. Vein should be distinct-easily visible

FIG. 12B

and/or palpable. Tourniquet should be tight enough to obstruct venous flow, but, not arterial flow (radial pulse should be palpable).

If vein is not prominent:

- a. Have patient open and close hand, making a fist, no more than 2 times.
- a. Opening and closing the fist more than 2 may increase lactic acid.
- b. Lightly tap vein site.
- c. Take tourniquet off, then place extremity in a dependent position for a few minutes.
- c. Promotes venous distention.
- d. If necessary, apply moist heat for a few minutes.
- d. Use wash cloth moistened with warm tap water.
- e. Reapply tourniquet.
5. Cleanse site and surrounding area with alcohol. Repeat if skin is unusually soiled. Using second clean alcohol sponge, wipe the site once with a downward stroke.
5. Allow to air dry completely to prevent burning at site and prevent hemolysis. Alcohol mixing with blood causes hemolysis.
6. Put on gloves.
7. Stabilize the extremity and using thumb, hold skin taut below prepped area just distal to intended puncture site.
8. At a 15 degree angle, insert the needle, bevel up, through the skin parallel to vein.
8. Parallel approach decreases rolling of vessel.

FIG. 12C

Docket No. H0649/7Q01

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

NURSING ACTIONS:

9. **Butterfly needle:**

Withdraw desired amount of blood
and then release tourniquet.

Straight needle with vacutainer:

Remove tube immediately after filling
And insert next tube.

10a. Recommended order of filling multiple
tubes:

- 1) Blood Cultures
- 2) Red top-no anticoag
- 3) Blue top
- 4) Purple top
- 5) Gray top
- 6) Green top

10b. Invert the tubes gently about 10 times.

Withdrw desired amount of blood
(ie., last tube almost filled). Then
release tourniquet.

11. When using the vacutainer, remove tube
from needle holder to relieve vacuum
before removing needle from vein.
12. Place gauze sponge over puncture site,
remove needle and then apply pressure
over site until bleeding stops. Ask patient
to keep arm straight.
13. Check venipuncture site before leaving
room.
14. If butterfly needle and syringe is used,
place blood in appropriate specimen tubes
following above recommended guidelines.
Label tubes, place in bags and send to lab
with appropriate requisition.

SPECIAL CONSIDERTIONS:

9. Release of tourniquet prior to
removal of needle prevents extravasation
of blood into tissue or excessive bleeding
from puncture site.

Release of tourniquet just before blood
Drawing is complete allows for a last
"surge" of blood into specien tubes.
However, if blood flow is sluggish, it is
best to leave tourniquet in place until the
desired amount of blood is obtained.

10a. The rule is to alawys collect blood in
the tube containing anticoagulant last.

10b. Blood needs to be mixed with the
additive in the tube for it to function
properly.

12. Bending the arm might cause a
hematoma.

13. If hematoma develops, apply warm
Moist soaks with wash cloth.

FIG. 12D

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Title: System, Method, and
Computer Program...

Applicant: Sternlicht

NURSING ACTIONS:

14. If butterfly needle and syringe is used,
place blood in appropriate specimen tubes
following above recommended guidelines.
Label tubes, place in bags and send to lab
with appropriate requisition.

SPECIAL CONSIDERATIONS:

REFERENCES:

Brunner and Suddarth (1988). Textbook of Medical-Surgical Nursing, (6th Edition). Philadelphia,
PA: J.B. Lippincott, p. 668.

College of American Pathologists (1996). So You're Going to Collect a Blood Specimen. An
Introduction to Phlebotomy. College of American Pathologists, Illinois.

Logston, Boggs, R., Woodridge-King, M. (1993). AACN Procedure Manual For Critical Care.
Philadelphia, PA: W. B. Saunders Company.

Milliam, Doris, A. (1987). Venous Blood Samples - Sharpen Your Drawing Skills. Nursing 87.
December, p. 56 - 61.

Nursing Procedures, second edition, (1996). Sprintghouse. Springhouse, PA

EXPERT RESOURCES:

Mary Liz Bilodeau, RNC, MS, CCRN
Critical Care CNS

Martha Martin, RN, MSN
Staff Specialist

Jill Pedro, RN, MSN, ONC
Clinical Nurse Specialist

PRACTICE AREA:

Department of Nursing

Department of Nursing

Department of Nursing

Approved: Council on Practice
Revised: Council on Practice /

FIG. 12E

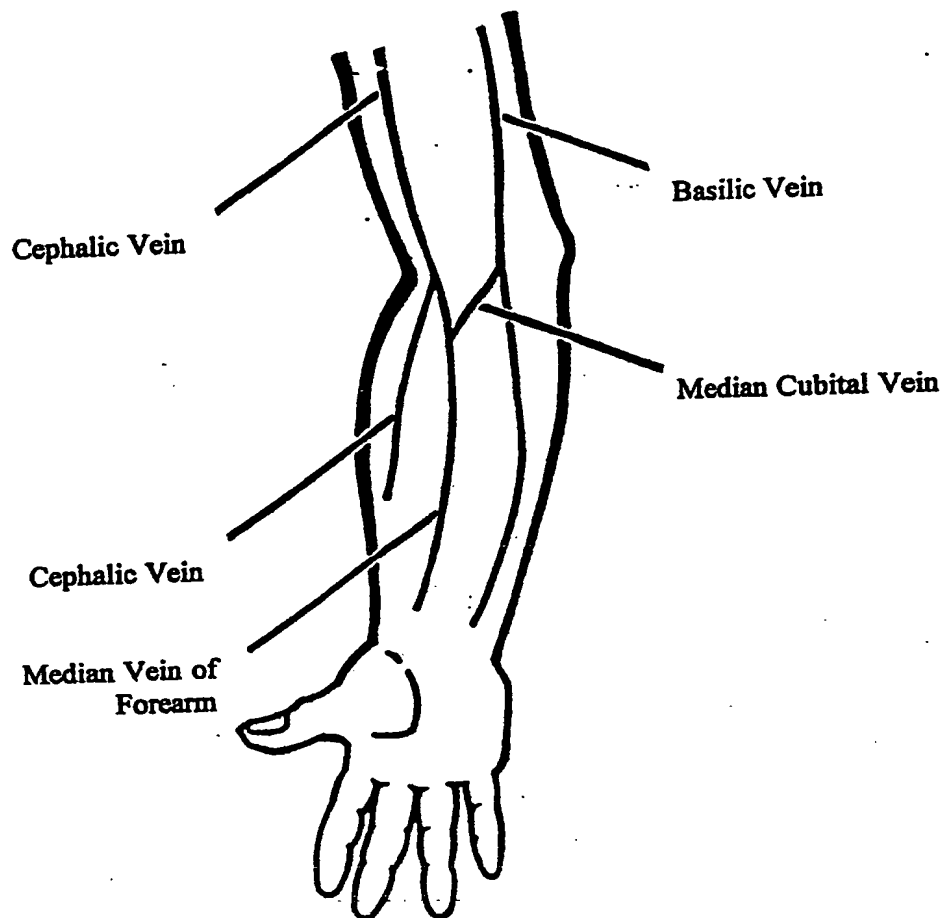


FIGURE 1 - Major Veins in Upper Extremity

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Name:

First	Initials	Last	Contact Telephone No:
-------	----------	------	-----------------------

Outward trip
From

mt	day	yr	time	:	am/pm	Service Required:
----	-----	----	------	---	-------	-------------------

Address

Address	
State	Zip code

Return trip
From

mt	day	yr	time	:	am/pm	Service Required:
----	-----	----	------	---	-------	-------------------

Address

Address	
State	Zip code

Notes on Required Nursing Services

Patient Information

Address:

--	--	--

City:

	State:	<table border="1"><tr><td></td></tr></table>		Zip:	<table border="1"><tr><td></td></tr></table>	

Phone - Home:

	Work:	<table border="1"><tr><td></td></tr></table>		Cell:	<table border="1"><tr><td></td></tr></table>	

email address:

	Fax:	<table border="1"><tr><td></td></tr></table>	

Payment Guarantor Information

Name:

First	Initials	Last
-------	----------	------

Address:

--	--	--

City:

	State:	<table border="1"><tr><td></td></tr></table>		Zip:	<table border="1"><tr><td></td></tr></table>	

Phone - Home:

	Work:	<table border="1"><tr><td></td></tr></table>		Cell:	<table border="1"><tr><td></td></tr></table>	

email address:

	Fax:	<table border="1"><tr><td></td></tr></table>	

Payment

Agreed fee for
above services
\$

Method	
Cash	
Check	
Invoice Company	
Other	

Credit Card Type	Amex	Visa
Card Number		
Issuer	Exp. Date	
Cardholder name shown on card		

Fig. 13

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Applicant: Sternlicht

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To receive a free and confidential quotation without obligation, please give the following information:

Name:		First	Initials	Last	Contact Telephone No:
Arrival date:	mth	day	yr	Total number in party:	
				adults:	
Departure date:	mth	day	yr	children:	
Type of accommodation				Total rooms required:	
single room					
twin-bedded double					
family room					
junior suite					
parlor suite					
Approximate nightly budget per room (excluding meals)					
\$150 - \$200					
\$200 - \$250					
\$250 - \$300					
\$300 - \$400					
\$400+					
				please state any particular requirements: (special meals, adapted bathrooms, wheelchair access etc.)	
				Near to any particular hospital? (if so please indicate which)	
Address:					
City:					
State:		Zip:			
Phone - Home:		Work:		Cell:	
email address:				Fax:	

FIG. 14

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Computer Program...
Applicant: Sternlicht

PATIENT REFERRAL INFORMATION:

DATE: ____/____/____

REFERRED BY:

(name) _____

(Phone) _____

(Dept.) _____

(Email) _____

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DOB: _____

DIAGNOSIS/PROCEDURE:

BRIEF MH/ALLERGIES:

ESTIMATED LENGTH OF STAY / TREATMENT: _____ days

REFERRING HOSPITAL _____

FLOOR _____ UNIT _____ ROOM NUMBER: _____

SURGEON: _____ PHONE: _____ FAX: _____

SERVICES TO BE PROVIDED: _____

DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

FIG. 15

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

PATIENT REFERRAL INFORMATION

DATE: ____/____/____

REFERRED BY: (Name)_____
(Phone)_____
(Dept.)_____
(Email)_____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DIAGNOSIS/PROCEDURE: _____

BRIEF PMH/ALLERGIES: _____

ESTIMATED LENGTH OF OUTPATIENT TREATMENT: _____ days/weeks/months

REFERRING HOSPITAL _____ FLOOR _____ ROOM NUMBER: _____

SURGEON/PHYSICIAN _____ PHONE: _____ FAX: _____

SERVICES
REQUESTED: _____

START DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

PAYMENT INFORMATION

Payment Guaranteed By:
Full Name: _____ (Relationship to Patient) _____

Address _____ Tel.No: _____

City _____ State _____ Zip _____ Email _____

METHOD OF PAYMENT: _____

CREDIT CARD DETAILS: _____

EXACT NAME ON CARD _____ EXPIRATION DATE _____

FIG. 16A

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Computer Program...
Applicant: Sternlicht

SUPPLIES:

Prescriptions to be filled/delivered _____ YES (Please attach scripts) _____ NO

Medical supplies needed: _____

Medical/Adaptive equipment needed: _____

CONCIERGE SERVICES:**HOTEL**

- ☐ Hotel preferences or price range: _____
- ☐ Number of Rooms: _____
- ☐ Number of Occupants; _____
- ☐ Arrival date/time: _____ (please note: most hotels have a 1p check in policy)
- ☐ Anticipated Date of Departure: _____

Room Preferences

BEDSIZE: _____ SMOKING/NON: _____ STANDARD/SUITE: _____

OTHER: _____

TRANSPORTATION:

- ☐ Nurse escort via car/airplane
- ☐ Wheelchair accessible van
- ☐ Ambulance
- ☐ Limousine
 - ☐ Pick up date, time, location: _____

AESTHETIC SERVICES:

- ☐ Massage: _____
- ☐ Facial: _____
- ☐ Manicure: _____
- ☐ Pedicure: _____
- ☐ Makeup application: _____
- ☐ Hair Services (Cut/wash/perm/set): _____

SPECIAL REQUESTS:

Fir 11 2

FIG. 17

PHYSICIAN ORDERS

- ☐
- Telephone Order Verification

RN/Clinician's Signature _____

Date _____

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 Computer Program...
 Applicant: Sternlicht
MEDICATION RECORD

FIG. 18

ALLERGIES _____

Patient _____

	MEDICATION		DATE	DATE	DATE	DATE	DATE	DATE	DATE
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							

INIT	SIGNATURE	INIT	SIGNATURE

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FIG. 19A

PATIENT INTAKE FORM

PATIENT NAME: _____ DOB: _____

GUARDIAN NAME (IF CHILD): _____

PRIMARY PHYSICIAN: _____

DIAGNOSIS: _____

ALLERGIES: _____

CURRENT ADDRESS: _____

LOCAL PHONE# / CELLULAR / PAGER: _____

RELIGION: _____

COUNTRY OF ORIGIN: _____

PERMANENT MAILING ADDRESS: _____

PRIMARY LANGUAGE: _____

METHOD OF PAYMENT: _____

SOURCE OF REFERRAL: _____

NAME AND # OF PERSON CALLING IN CASE: _____

DATE OF ADMISSION: _____ DATE OF DISCHARGE: _____

START DATE OF SERVICES: _____

DOCTORS ORDERS: _____

Applicant: Sternlicht

ANTICIPATED LENGTH OF TREATMENT: _____

ADDITIONAL THERAPIES:

☐ OCCUPATIONAL THERAPY: _____

☐ PHYSICAL THERAPY _____

☐ SPEECH THERAPY: _____

☐ RESPIRATORY THERAPY: _____

☐ INFUSION SERVICES: _____

☐ ESCORTING TO APPOINTMENTS: _____

☐ SCHEDULE FOLLOW UP APPT: _____

☐ TRANSPORTATION: _____

☐ LIVING ACCOMODATIONS: _____

☐ OTHER: _____

DATE/TIME/SIGNATURE OF INTAKE WORKER: _____

PRIMARY NURSE ASSIGNED TO CASE: _____

FIG. 19B

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Computer Program...
Applicant: Sternlicht

FIG. 20

CONCERGE

☐ HOTEL: _____ ARRIVAL: _____ DEPARTURE: _____

ROOM PREFERENCES:

BEDSIZE: _____ SMOKING: _____ STANDARD/SUITE: _____

OTHER PREFERENCES: _____

☐ TRANSPORTATION:

PICKUP DATE/TIME/LOCATION: _____

☐ MEALS: _____

☐ AESTHETIC SERVICES:

☐ MASAGE: _____

☐ FACIALS: _____

☐ MAINCURE: _____

☐ PEDICURE: _____

☐ MAKEUP APPLICATION: _____

☐ OTHER: _____

COMMENTS: _____

FOR OFFICE USE ONLY: (PLEASE INITIAL WHEN COMPLETED)

- ☐ STAFF ASSIGNED:
- ☐ HOTEL BOOKED:
- ☐ TRANSPORTATION CONFIRMED
- ☐ PATIENT NOTIFIED OF ALL DETAILS IN WRITING:
- ☐ CONTACT MADE WITH SURGICAL TEAM:
- ☐ PATIENT INVOICED:
- ☐ FOLLOW UP LETTER SENT TO PATIENT:
- ☐ FOLLOW UP LETTER SENT TO PHYSICIAN:

FIG. 21

Patient _____

[illegible]

FIG. 22

Patient Name _____ **DOB** _____

INTAKE						
DATE TIME	ORAL AMT/Subtotal	IV AMT/Subtotal	PCT AMT/Subtotal	DATE TIME	URINE AMT/Subtotal	STOOL AMT/Subtotal
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
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DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						

Fig. 23

PATIENT TIME SHEET: NURSING

Month

Patient Name

Location

Patient Signature

Staff Signature

Date of Mo	Shift 1			Shift 2			Shift 3			Total Hours
	Nurse Name	Time In	Time Out	Nurse Name	Time In	Time Out	Nurse Name	Time In	Time Out	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
Totals										

Docket No. H0649/7001
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 Computer Program
 Applicant: Sternlicht

Docket No: H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 24A

**PHYSICAL THERAPY
Initial Evaluation**

Date:

Name	
Parent	
Address	
Date of Birth	Gestational age
Diagnosis	

Physician
Case Manager
Primary PT
Chief complaint

SUBJECTIVE

PMH:

Social hx

Prior level of functioning:

Precautions:

Hx of present illness:

Pain

Medications

MUSCULOSKELETAL ASSESSMENT

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

Joint range of Motion ☐ WNL

Motion		Position		Motion		Position	
				Right	Left	Right	Left

Muscle Strength ☐ WNL

Muscle		Position		Grade	
				Right	Left

Muscle Tone

Sensory

REFLEX PROFILE

Supine

Prone

Sitting

Quadruped

Standing/vertical Suspension

Horizontal Suspension

Er 21.2

GROSS MOTOR EVALUATION Title: System, Method, and
Computer Program...
Applicant: Sternlicht

Prone

Supine

Sitting

Quadruped

Kneeling

Half Kneeling

Standing

Ambulation

Stair Climbing

Ball Skills

Balance

Static

Dynamic

Standing

Sitting

FIG. 24C

FINE MOTOR ASSESSMENT

Docket No. H0649/7001

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

Focus/Visual Tracking**Approach****Grasp****Manipulation****Release****Transferring****Bilateral Activities****ACTIVITIES OF DAILY LIVING****Feeding****Dressing****Hygiene**

FIG. 24M

EQUIPMENT

Docket No. H0649/7001

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

SUMMARY**Assessment:****Problems:****Plan of Care:****Goals:****Expected Visits**

Signature _____ PT

Date _____

FIG. 24E

FIG. 25

PATIENT TIME SHEET: THERAPY VISITS

Month

Patient Name
Location

Patient Signature
Staff Signature

Date of Mo	SHIFT 1				SHIFT 2				SHIFT 3				
	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	
1													
2													
3													
4													
5													
6													
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Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

Pocket No. H0649/7001
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Computer Program...
Applicant: Sternlicht

FIG. 26

PHYSICIAN MEMORANDUM

Date: _____

Physician: _____ Office/Fax: _____

Patient: _____ DOB: _____

☐ Patient Status Update

☐ Additional Service Request

☐ Orders

☐ Other

Comments:

R.N./Clinicians Name _____ Contact Number: _____

Reply:

Physician's Signature: _____ Date: _____

FIG. 27

NAME AGE ALLERGIES		CV	RESP	TEACHING / PARENTS
HISTORY				
DEVELOPMENT		NUTRITION	ELIMINATION	APPOINTMENTS
		Central	U/O	ISSUES TO RESOLVE
		PGT	Vomit	
SKIN / DSGS		PO	Stool	
		Weight	Other	
Mouthcare				

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FIG. 28A

TO BE COMPLETED BY THE PATIENT, FAMILY MEMBER OR NURSE		FOR NURSE USE ONLY																					
1. What language do you speak? _____ 2. Why do you need home care services? _____ 3. Do you have ALLERGIES to medicines/ latex/ food? If yes, list _____ 4. What is the hospital you are being treated at? _____ 5. Who is your primary doctor? _____ 6. Are there other doctor's involved in your care? _____ 7. Do you smoke? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 8. Do you use recreational drugs? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 9. Do you use alcohol? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 10. Please list all medications you are presently taking below <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Medication</th> <th style="width: 33%;">Dose</th> <th style="width: 33%;">Purpose</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Medication	Dose	Purpose																			HEALTH PERCEPTION MANAGEMENT <input type="checkbox"/> Needs health teaching <input type="checkbox"/> Needs med teaching
Medication	Dose	Purpose																					
11. Do you have enough information about your medications? <input type="checkbox"/> no <input type="checkbox"/> yes 12. Do you have any problems with your bowels? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 13. Do you have any problems with urinating? _____		ELIMINATION <input type="checkbox"/> Needs output regimen																					
14. Do you have any problems with your intake of food? (eating, swallowing, chewing, nausea/vomiting)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 15. Do you follow any special diets? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 16. Does you have any skin problems? (rashes, bruises, reactions, cut, bumps)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____		NUTRITION/ METABOLIC <input type="checkbox"/> Needs nutrition teaching <input type="checkbox"/> Needs nutrition material																					
17. Are there any limitations to your activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ 18. Do you need assistance with any daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ 19. Do you have or need any special equipment? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____		ACTIVITY/EVERCISE <input type="checkbox"/> PT needed <input type="checkbox"/> OT needed																					

Doc No. H0649/7001
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20. Do you have any problems sleeping? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	SLEEP/REST
21. Do you have enough energy for your daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	
22. Do you have any problems with <input type="checkbox"/> memory <input type="checkbox"/> vision <input type="checkbox"/> hearing? Describe _____	COGNITIVE/ PERCEPTUAL
23. Do you any questions or concerns about your sexuality/reproductive system? <input type="checkbox"/> no <input type="checkbox"/> yes List _____	SEXUALITY/ REPRODUCTIVE
24. How are you coping with your health issues at the present time? _____	COPING/STRESS
25. Has your illness changed your life significantly? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	SELF PERCEPTION
26. Who are the important people to be involved in your care? _____	ROLE/RELATIONSHIP <input type="checkbox"/> Proxy in chart
27. Who shall we contact in the event of any emergency? _____ Telephone _____	
28. Do you have a health care proxy? <input type="checkbox"/> no <input type="checkbox"/> yes name _____	
29. Are there any religious practices that we can support? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	VALUE/BELIEF
30. Are there any needs medically and personally that we can assist you with? <input type="checkbox"/> no <input type="checkbox"/> yes List _____	
NURSING ISSUES TO BE ADDRESSED	
Information obtained from _____	
Nursing Signature _____ Date _____	

[illegible]